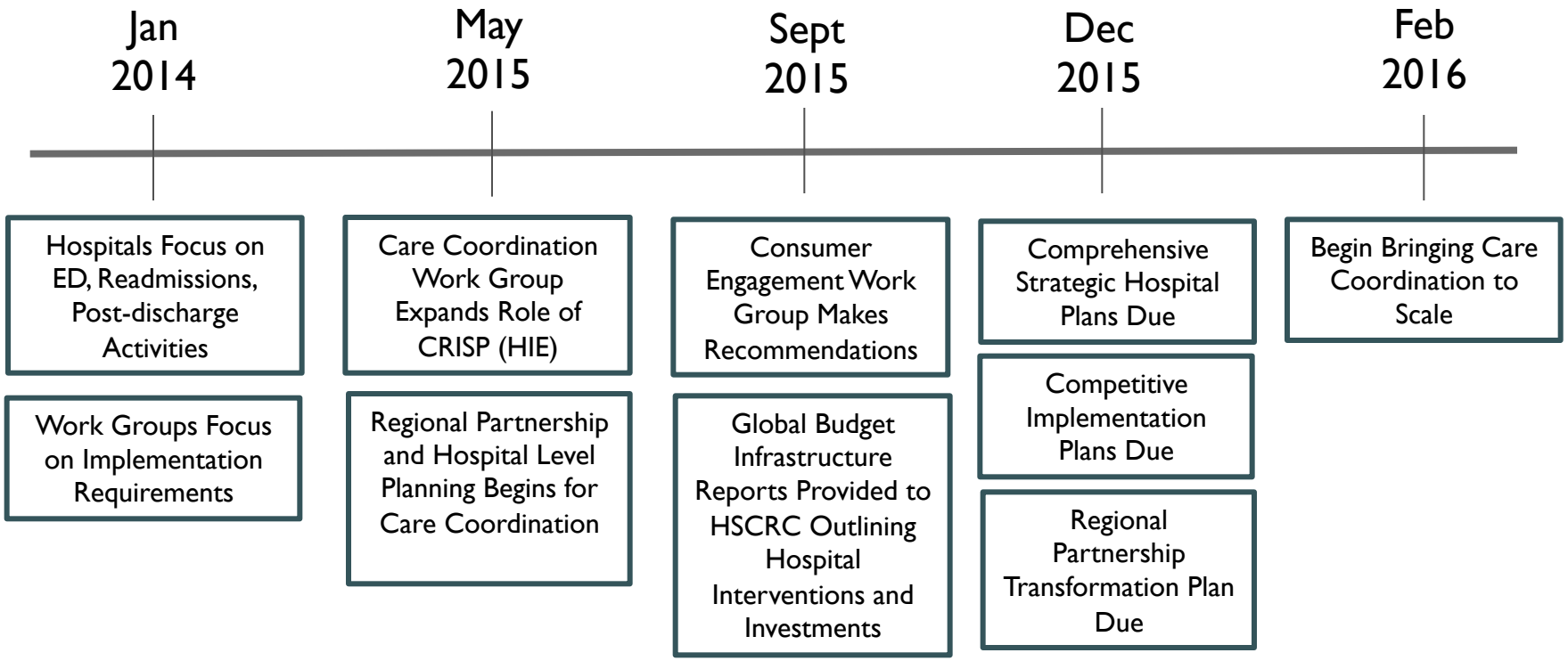
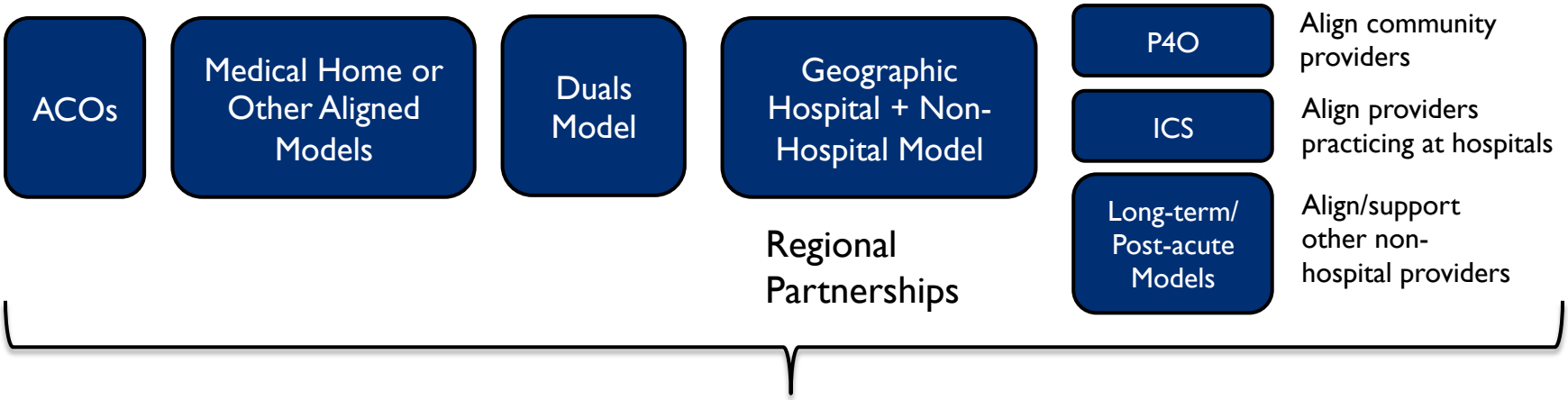
# Transformation Planning is Underway with a Focus on Complex High-Needs Individuals and Chronic Conditions



# Potential Long-Term Developments




**Models Supported By:**

- Data & Financial Incentives for Providers
  (Alignment tools and data for P4O, ICS, , etc.)
- Common Technology Tools
  (Via CRISP: risk stratification, care profiles, etc.)
- Care Coordination Resources

**Common Goals:**

- Reduce Potentially Avoidable Utilization
- Improve Quality, Outcomes
- Person-Centered Care
- Reduce Spending Growth
- All Payer Hospital Model
- Aligned Non-hospital Models

# Two Potential New Programs: Creating Alignment Across Hospitals & Providers

- 1. Internal Cost Savings (ICS) Program for providers practicing at hospitals
  - Designed to reward improvements in efficiency and cost savings in all services delivered for an acute care event, including readmissions
- 2. Pay for Outcomes (P4O) Program for non-hospital providers
  - Incentives for high-value activities focused on high needs patients—Complex and rising needs, such as dual eligible patients
- Hospitals will be able to share resources with hospital and non-hospital providers through these programs as long as quality targets are met, costs do not shift and the total cost of care does not rise above a benchmark.

# Internal Cost Savings (Gainsharing) Program

- Goal: Reward improvements in the quality of hospital encounters and transitions in care that will create internal hospital cost savings
- Activities that may be included:
  - Care coordination and discharge planning
  - Evidence-based practice support
  - Patient safety practices
  - Harm prevention such as self-reporting adverse events
  - Staff development such as CPOE training
  - Efficiency and cost reduction such as discharge order by goal time

# Pay for Outcomes (P4O) Program

- Goal: Address the needs of complex patients and those patients with chronic conditions that would qualify for Medicare's CCM fee and other available non-visit fees, tying resources from hospitals together with resources from Medicare payments to providers
  - By tying such programs together, a chronic medical home is created for these high needs persons, including beneficiaries in long-term care
- Activities that may be included:
  - Care management, such as using HRAs and creating care plans
  - Care coordination, such as obtaining discharge summary, updating records, and reconciling medications
  - Access to care, such as after-hours care or transportation
  - Risk stratification
  - Community activities (e.g. services outside traditional office setting)
  - Post-acute and long term care redesign, such as deploying health professionals to settings or using telemedicine